STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	08/19/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
TRANSCENDENT HEALTHCARE OF BOONVILLE, LLC	725 SOUTH SECOND ST BOONVILLE, IN47601

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F0000	This visit was for the Investigation of Complaint IN00094056. This visit resulted in a partially-extended survey-Immediate Jeopardy. Complaint IN00094056 - Substantiated. Federal/State deficiencies related to the allegations are cited at F201, F203, F240, F323, F514, F9999. This visit was completed in conjunction with the PSR (Post Survey Revisit) to the Recertification and State Licensure survey completed on 6/27/11. Survey date: August 18, 2011 Extended Survey date: August 19, 2011 Facility number: 000451 Provider number: 155508 AIM number: 100266240 Survey Team: Carole McDaniel RN TC Terri Walters RN Martha Saull RN Census Bed Type: SNF/NF: 64 SNF: 1 Total: 65	F0000	September 6, 2011 Kim Rhoades Indiana State Department of Health Long Term Care Division 2 North Meridian Street Indianapolis, Indiana 46204 Dear Ms. Rhoades, Attached you will find the plan of correction for the most recent survey. Please accept our plan of correction as our allegation of compliance effective August 29, 2011. We respectfully request that a follow-up survey occur in the near future. We believe that the facility has implemented all necessary interventions to assure compliance. If you have any questions, or require further information, please don't hesitate to contact me. Respectfully Submitted, Michael Van Hoy, Administrator Transcendent Healthcare of Boonville 812-897-1375	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	Census Payor Type: Medicare: 13 Medicaid: 42 Other: 10 Total: 65 Sample: 4 Supplemental sample: 2 These deficiencies also reflect state findings cited in accordance with 410 IAC 16.2. Quality review 8/26/11 by Suzanne Williams, RN			

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F0201 SS=G	The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; The safety of individuals in the facility is endangered; The health of individuals in the facility would otherwise be endangered; The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or The facility ceases to operate. Based on interview and record review, the facility failed to ensure the necessity of 2 attempted discharges of 1 of 3 residents reviewed for discharge rationale from a sample 4. This resulted in treatment being required for a panic attack in a resident awaiting heart surgery. Resident A Findings include:	F0201	**F201 It is the practice of Transcendent Healthcare of Boonville to always assure that residents are not inappropriately discharged.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #A continues to reside on the secure unit. The facility is working with the guardian, ombudsman and the MR/DD caseworker for more appropriate placement since this	08/29/2011

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	The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included, but were not limited to, schizophrenia, autism, developmental disability and heart disease with related heart surgery scheduled. The resident had been admitted to Transcendent nursing home on 2/3/11 and on 6/26/11 eloped from the facility, fractured her arm during the elopement, was sent to a local ER and transferred to a Psychiatric Hospital. Documentation of nurses' notes, Social service notes, or any verification of the event and related issues of transfer/ discharge by documentation was "missing" according to the Director of Nursing (DON)during interview on 8/19/11 at 9:30 A.M. and the Social Service Designee (SSD)on 8/19/11 at 1:50 P.M.. The business office record of transfer and discharges indicated the resident was hospitalized on 6/26/11, discharged from the facility on 7/1/11 and readmitted to the facility on 7/8/11. During the SSD interview 8/19/11 at 1:50 P.M. she indicated she had worked with the discharge planners at the Psychiatric hospital in relation to taking Resident A back "But when the Ombudsman came was when we decided to take her back." Discharge Planner #1 at the Psychiatric		resident verbalizes a desire to reside with residents in her age group. There has not been a transfer/discharge notice initiated for this resident nor will there be until all parties are in agreement. ***Other residents that have the potential to be affected have been identified by:*** There have been no residents that have been discharged from the facility unless it has been by their choice. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The facility has carefully reviewed the regulations related to transfer/discharge. Nurses and Social Services has been in-serviced related to requirements related to transferring or discharging a resident. Transfers/Discharges will only be initiated in accordance with the regulatory guidelines. Involuntary Transfer/Discharge Notices will only be initiated in accordance with the regulations after an Interdisciplinary Team Review and with close communication with the ombudsman prior to any notice being issued. Please see below for systems to monitor. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) that have	

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	hospital was interviewed on 8/19/11 at 2:10 P.M. The planner indicated good recall of the discharge and concern for "How (resident name) could have eloped and broke her arm." The planner indicated when the resident was stable and able to be managed in a nursing home the Transcendent home would not allow her back. The planner indicated working on alternative placement until the intervention of the ombudsman on behalf of the family resulted in the resident being returned to Transcendent on 7/8/11. The planner indicated the facility was fearful she would elope again and did not want her back. On 8/17/11 at 3:50 P.M. the area Ombudsman was interviewed. She indicated she was requested to advocate for the resident by the resident's guardian when Transcendent refused readmission to the resident. The Ombudsman recounted going to the facility to work with the facility to gain resident readmission. The facility took the resident back utilizing the option of placement on their locked secure unit with enhanced supervision and security. She indicated the family was concerned to have the resident living as near to them as possible. An undated communication from the		transferred/discharged from the facility to assure that this occurred in accordance with the guidelines. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed ***The date the systemic changes will be completed:*** 8-29-11	

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	Administrator to the staff of the secure locked Seasons unit (where Resident A was admitted on 7/8/11) was posted in the elopement information and monitoring book for Resident A. It included the facility intention "Her placement here is only for temporary reasons. We anticipate her to be discharged early in the week of 7/10/11." On 8/18/11 at 8:30 P.M. an interview with the area Ombudsman by phone indicated Transcendent had notified Resident A's guardian/mother that evening at 6:10 P.M., that the resident was being discharged and the guardian was to pick the resident up as they were no longer able to care for her since they had received an Immediate Jeopardy Notice (IJ) from the ISDH related to the resident's July elopement .The ombudsman notified the guardian not to comply with the facility directive and visited the facility. A follow up written report to ISDH of the events included the following : "Guardian was relieved not to have to remove the resident with care needs she can't meet...The resident had been told by staff to pack her things; that she was going home with her mother. Resident was visibly upset and complaining of chest pain at 9:21 PM." Excerpts from the 8/18/11 nurse's notes			

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	entered for the above event were as follows: 9:00 P.M.. Resident has been upset on and off this shift related to possible leaving facility. Becomes very tearful. At this time 'my chest hurts' then 'I can't breathe'." The O2 saturation was 98% the vital signs were B/P 158/84 Pulse 84 respirations 22. " While saying she could not breathe the resident was yelling out. Staff and Ombudsman were able to redirect the resident and for seconds will laugh then cry." The resident requested to speak to her physician (a family relative) at home, did so, and the nurse then spoke with the physician at 9:45 PM. The physician gave a new order "Benadryl 25 mg now and let her smoke 2 cigarettes that should help because resident "is having an anxiety/panic attack." At 11:00 P.M. the resident was in bed with eyes closed and offered no further complaints of chest pain, shortness of breath or anxiety." On 8/19/11 at 2:30 P.M. the Seasons Unit Director and the DON were interviewed regarding the status of Resident A on the seasons unit since her readmission on 7/08 until the attempted discharge on the evening of 8/18/11. They indicated the resident was not a danger to herself or to others, had identified no danger of harm to her or others related to her residence there and			

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	had not had any problems on the unit. They indicated she was being transferred because they had been informed the July elopement was an Immediate Jeopardy. The DON stated "We did that last night because I understood the Immediate Jeopardy meant she was in danger. I understand better now. I had input on the discharge decision but did not have the final decision which the Administrator and Owner made." This federal tag relates to complaint IN00094056. 3.1-12(a)(4)			

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F0203 SS=D	Before a facility transfers or discharges a resident, the facility must notify the resident and, if known, a family member or legal representative of the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand; record the reasons in the resident's clinical record; and include in the notice the items described in paragraph (a)(6) of this section. Except when specified in paragraph (a)(5)(ii) of this section, the notice of transfer or discharge required under paragraph (a)(4) of this section must be made by the facility at least 30 days before the resident is transferred or discharged. Notice may be made as soon as practicable before transfer or discharge when the health of individuals in the facility would be endangered under (a)(2)(iv) of this section; the resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (a)(2)(i) of this section; an immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (a)(2)(ii) of this section; or a resident has not resided in the facility for 30 days. The written notice specified in paragraph (a)(4) of this section must include the reason for transfer or discharge; the effective date of transfer or discharge; the location to which the resident is transferred or discharged; a statement that the resident has the right to appeal the action to the State; the name, address and telephone number of the State long term care ombudsman; for nursing facility residents with developmental disabilities, the mailing address and telephone			

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	number of the agency responsible for the protection and advocacy of developmentally disabled individuals established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act; and for nursing facility residents who are mentally ill, the mailing address and telephone number of the agency responsible for the protection and advocacy of mentally ill individuals established under the Protection and Advocacy for Mentally Ill Individuals Act.			
	Based on record review and interview the facility failed to provide transfer discharge notice, rationale, and appeal information to 1 of 3 residents reviewed for transfer and discharge in a sample of 4. Resident A Findings include: The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included, but were not limited to, schizophrenia, autism, developmental disability and heart disease. The resident had been admitted to Transcendent nursing home on 2/3/11. Business office records indicated the resident had been transferred to a hospital on 6/26/11 following an elopement and discharged on 7/1/11. Documentation was lacking in the medical record to indicate the required transfer discharge notice, reasons for the discharge and appeal rights information had been provided to either the resident, guardian or the hospital.	F0203	**F203 It is the practice of Transcendent Healthcare of Boonville to assure that the resident is provided the Transfer/Discharge Notice and Bed Hold Policy at the time of transfer.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident A has had no additional transfers from the facility. The transfer/discharge notice and bed hold notice identified in the 2567 has not been located. Please refer to systems below related to preventing reoccurrence of this area ***Other residents that have the potential to be affected have been identified by:*** Per review of our recent transfers to the hospital, a Transfer/Discharge Notice and Bed Hold policy were sent at the time of transfer. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** Packets have been initiated that include the	08/29/2011

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	In interview with the Director of Nursing on 8/18/11 at 1:00 P.M. and 8/19/11 at 11:00 A.M., she indicated information that would normally be included in the medical record was missing. In interview with the Social Service Designee on 8/19/11 at 1:50 P.M. she stated the appropriate documentation and "all the forms we usually send about that" were "probably missing with the rest of the stuff from the chart." This federal tag relates to complaint IN00094056. 3.1-12(a)(9)		presence of the Transfer/Discharge Notice and Bed Hold policy to be sent with a resident at the time of transfer. The nurses will be utilizing these packets when transferring a resident. The nurses have all been in-serviced related to assuring that the transfer/discharge notice and bed hold policy is sent at the time of transfer. In addition, the Interdisciplinary Team will be reviewing transfers of residents to assure that the proper information was sent at the time of transfer. Any findings would be immediately corrected. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) that have transferred/discharged from the facility to assure that the Transfer/Discharge Notice and Bed Hold policy were sent at the time of transfer. The PI tool will also review any involuntary discharges to assure all proper protocol was followed. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed ***The date the***	

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			systemic changes will be completed: 8-29-11	
F0240 SS=G	A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life. Based on interview and record review, the facility failed to provide a calm, assistive environment while intending to discharge 1 of 1 resident on the specialty dementia unit whom the facility was in the process of relocating from a sample of 4. This resulted in anxiety with associated panic attack requiring treatment. Resident A Findings include: The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included, but were not limited to, schizophrenia, autism, developmental disability and heart disease with scheduled heart surgery impending. The resident had been re admitted to Transcendent nursing home on 7/8/11 2/3/11 from a Psychiatric Hospital. The Minimum Data Set Assessment of 6/26/11 indicated the resident's cognition to be moderately impaired with a score of 12 (8-12 moderate impairment, 13-15 cognition intact). It indicated the resident was independent in transfers and ambulation and was always easily distracted or out of touch or had difficulty following what was said.	F0240	**F240 It is the practice of Transcendent Healthcare of Boonville to assure that our residents are provided a calm environment.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident A remains on the locked unit. The resident has remained calm and has not exhibited signs of undue stress or additional panic attacks. As indicated in the 2567, the issue involved related to transfer/discharge. Therefore, that is the system that will be addressed to assure that there is proper planning and undue stress on the residents ***Other residents that have the potential to be affected have been identified by:*** Per review of our residents, there have been no issues where any of the residents have exhibited signs of additional stress based on a decision made by the facility. As indicated in the 2567, the issue involved related to transfer/discharge. Therefore, that is the system that will be addressed to assure that there is proper planning and undue stress on the residents should it occur. ***The measures or systematic***	08/29/2011

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	On 8/18/11 at 8:30 P.M. an interview with the area Ombudsman by phone indicated Transcendent had notified Resident A's guardian/mother at 6:10 P.M. that evening that the resident was being discharged, and the guardian was to pick the resident up from the Seasons unit. They indicated were no longer able to care for her since they had received an Immediate Jeopardy Notice (IJ) from the ISDH related to the resident's July elopement .The ombudsman notified the guardian not to comply with the facility directive and visited the facility at 8:30 P.M. in hopes of preventing a sudden traumatic discharge. A follow up written report to ISDH of the events included the following : "Guardian was relieved not to have to remove the resident with care needs she can't meet...The resident had been told by staff to pack her things; that she was going home with her mother. Resident was visibly upset and complaining of chest pain at 9:21 PM." Excerpts from the 8/18/11 nurse's notes entered for the above event were as follows: 9:00 P.M. Resident has been upset on and off this shift related to possible leaving facility. Becomes very tearful. At this time 'my chest hurts' then 'I can't breathe'." The O2 saturation was 98% the vital signs		***changes that have been put into place to ensure that the deficient practice does not recur include:*** The facility has carefully reviewed the regulations related to transfer/discharge. Nurses have been in-serviced related to requirements related to transferring or discharging a resident. Transfers/Discharges will only be initiated in accordance with the regulatory guidelines. Involuntary Transfer/Discharge Notices will only be initiated in accordance with the regulations after an Interdisciplinary Team Review and with close communication with the resident, guardian, and ombudsman prior to any notice being issued. In the event that the transfer is necessary not related to an emergency situation, proper planning and orientation for the resident will occur to assist with decreased anxiety related to the any transfer. Please see below for systems to monitor. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (if applicable) that have transferred/discharged from the facility to assure that the transfer/discharge was completed in a manner that supports proper orientation for the resident to decrease any anxiety. The Director of nursing, or designee,	

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	were B/P 158/84 Pulse 84 respirations 22. " While saying she could not breathe the resident was yelling out. Staff and Ombudsman were able to redirect the resident and for seconds will laugh then cry." The resident requested to speak to her physician (a family relative) at home, did so, and the nurse then spoke with the physician at 9:45 PM. The physician gave a new order "Benadryl 25 mg now and let her smoke 2 cigarettes that should help because resident "is having an anxiety/panic attack." At 11:00 P.M. the resident was in bed with eyes closed and offered no further complaints of chest pain, shortness of breath or anxiety." On 8/19/11 at 2:30 P.M. the Seasons Unit Director and the DON were interviewed regarding the status of Resident A on the seasons unit since her readmission on 7/08 until the attempted discharge on the evening of 8/18/11. They indicated the resident was not a danger to herself or to others, had identified no danger of harm to her or others related to her residence there and had not had any problems on the unit that warranted an immediate evening transfer without preparation for or assistance to the resident or family. This federal tag relates to complaint IN00094056.		will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed ***The date the systemic changes will be completed:*** 8-29-11	

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	155508	A. BUILDING 00 B. WING	08/19/2011

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F0323 SS=J	3.1-32(a) The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on observation, interview and record review, the facility failed to provide services to prevent elopement, resulting in wrist fracture and hospitalization for 1 of 1 residents who had eloped in a sample of 4 (Resident A). In addition to Resident A in Immediate jeopardy, the facility failed to adequately identify, assess and implement an effective security system for 12 other residents at risk of elopement out of the facility census of 65. (Residents B, C, D, E, F. J, K, L, M, N, O, P) The immediatte jeopardy began on6/26/11 when Residentt A eloped firom tthe fiacilitty, fell and firacttured her wristt The Administtrattor and Directtor ofi Nursing were nottfied ofi tthe immediatte jeopardy att 3:30 p.m. on 8/18/11. The immediatte jeopardy was removed on 8/19/11, buttt noncompliance remained att tthe lower scope and severitty level ofi patterno acttual harm witth pottenttal fior more tthan minimal harm tthatt is nott immediatte jeopardy. Findings include:	F0323	**F323 It is the practice of Transcendent Healthcare of Boonville to assure that our residents are in a safe, secure environment. We believe we took appropriate actions for resident A when she returned from the hospital. The resident was placed on the secure unit at that time. All of the residents that are at risk of elopement, with the exception of one, reside on the secure unit. The exception is a dependent resident who mobilizes per wheelchair and would not be able to open the doors to leave the facility per self. This facility does not have a history of residents eloping from the facility and will continue to strive to assure that this type of incident does not occur.** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident A remains on the secure unit. The resident's elopement assessment has been updated with an Interdisciplinary Team review and narrative as	08/29/2011

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	The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included but were not limited to schizophrenia, autism, developmental disability and heart disease. The resident had been admitted to Transcendent nursing home on 2/3/11. The Minimum Data Set Assessment of 6/26/11 indicated the resident's cognition to be moderately impaired with a score of 12 (8-12 moderate impairment, 13-15 cognition intact). It indicated the resident was independent in transfers and ambulation and was always easily distracted or out of touch or had difficulty following what was said. The 7/06/2011 Interdisciplinary Diagnostic and Evaluation Center Significant change analysis provided the only available intact account of the resident's elopement in the clinical record that could be located, according to interview with the Director of Nursing on 8/18/11 at 1:30 P.M. Excerpts from that analysis are as follows: "...admitted to Transcendent 2/3/11...admitted to (Name) Psychiatric Hospital in March 2011 where she was held for 72 hours due to threats to leave the nursing facility...most recent admission to [psychiatric hospital] was on		well as the plan of care has been updated. Residents B, C, D, E, F, J, K, L, M, N, O, and P have been reviewed and had elopement assessments updated with an Interdisciplinary Team review narrative as well as the plan of care has been updated. The elopement binder has been updated to be inclusive of each of the residents identified above. ***Other residents that have the potential to be affected have been identified by:*** All residents have been reviewed related to risk for elopement with their assessments updated. Any resident identified to be at risk for elopement has a plan of care in place with appropriate interventions related to assuring resident is safe. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** At the time of admission, quarterly, and/or if there is a change of condition, the resident will have an elopement assessment completed. The Interdisciplinary Team will review this assessment and make a narrative note related to the elopement risk. Appropriate interventions will be implemented and identified on the plan of care. Any resident identified to be at risk for elopement, will have their picture as well as descriptive information placed in the elopement book. The elopement	

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	6/27/2011 after she snuck out of the nursing facility after 11:00 P.M. on 6/26/11, walked to a convenience store, fell on her walk back, and broke her right arm...(Resident name) had reported she had asked for a cigarette but she was told she did not have any. Reportedly she went back to her room, dressed in street clothes, then snuck out through a dining room door. (Resident name) had the code to exit the door without setting off the alarm system as she was able to go in and out to a side porch for smoking times. (Resident name) then walked to a (Name) store, about a mile from the nursing facility and fell on her return walk back. She related afterwards, she was going to purchase cigarettes. However, her roommate at the nursing facility told staff that (Resident name) was going to meet a man the roommate knew and had arranged to meet (Resident name). The man's name was learned but it is not known if (Resident name) actually met up with him. When the nursing facility did their resident census at midnight they found she was missing from her bed. After a search of the facility with administrative personnel called in to help search and family notified, the facility received a call from (Name) Hospital Emergency Room to inform them the resident had been brought there for treatment.		book will be kept updated as new residents are admitted or there is a change in a current resident's status. In addition, the door key pad codes have been changed and will be changed on a routine basis. The knowledge of the key pad codes will not be shared with the residents. All staff has been in-serviced related to elopement risk and interventions, the keypad code changes, and the location of the elopement book. Please see below for systems for monitoring. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents (especially know residents with risk for elopement combined with all residents) to assure that all interventions are in place to assure their safety.. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed ***The date the systemic changes will be completed:*** 8-29-11	

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	In relation to the above noted March 72 hour hospitalization, following threats to leave the nursing home, there was corresponding documentation in the business office of a hospitalization on March 14, 15, 16, 2011 followed by readmission to the facility. A 3/14/11 social services note included the resident "States she is leaving today. 'I am going back to my husband'...Dr (name) told nurse the cops will be here today to take (resident) to the hospital to get an evaluation and hold her 72 hours." A 3/18/11 social service note after the return of the resident to the facility indicated a continuing resident agenda to leave "tearful and somewhat angry because she wants her money so she can leave with her husband." Documentation was lacking of an elopement risk assessment until 5/2/11. The front page of this assessment was completed; however, the back page categories for summary, conclusions/recommendations and interventions were blank with the signature of the LPN responsible entered at the bottom of the page. The Care Plan from 3/28/11, after the hospitalization for threats to leave, did not address wandering/ elopement risk. The elopement risk was not addressed until			

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	7/10/11, after the elopement and injury with hospitalization and return to the nursing facility's locked secured unit. That care plan had a single intervention "secured unit." Documentation was provided by the facility on 8/18/11 at 11:15 A.M. regarding an investigation of the 6/26/11 elopement, with witness accounts. Excerpts included: From the investigation portion, "At 9:00 P.M. (6/26) the documentation indicated that the resident was still angry and stated that if the guy shows up, she is leaving the facility and no one is going to stop her..." From the night shift CNA witness statement "...around 11:00 P.M. (Resident name) was on the back porch sitting." From the RN witness statement "At 11:15 P.M. asked this nurse for cigarettes and wanted to smoke. Was upset when I told her I did not smoke and felt it was late and dark outside. She was upset and started to talk about events that happened earlier in the day...offered opportunity to verbalize and invited to stay at the nurses station to talk...would not reply and at 11:30 P.M. returned to her room...At 12 midnight census bed check the resident was recognized to be missing...search			

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	began and at 12:55 A.M. the hospital called to report the resident admission to the ER." Documentation was lacking to identify facility assessment of elopement risk, preventive monitoring of security breaches i.e. resident knowledge of codes, resident outdoors at night unsupervised, resident expressed elopement ideation or a plan of care to address these problems. Documentation of the event of the 6/26/11 elopement was absent from the medical record as well as all documentation of any staff responses, notifications or communications with either the first hospital ER or the psychiatric hospital to which the resident was sent. During interview with the current DON on 8/18/11 at 1:00 P.M. and on 8/19/11 at 9:30 A.M.,she indicated the documentation was "missing" and she was at a loss to know what happened to it, and believed it could not be located. On 8/18/11 the undated policy and procedure for elopement prevention was reviewed. It directed "Obtain information during pre-admission screens with the resident and family regarding any history of wandering or a potential for wandering. All instances of wandering or attempted elopement will be recorded in the medical			

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	record. Upon assessment, Care Plan will be developed and implemented with specific approaches and goals for the wanderer. Upon assessment if a resident is identified as an elopement risk the resident's name, picture and physical description are placed in the wander book located at the nurses station." On 8/18/11 the facility identified 13 residents at risk of elopement in the facility. They were Residents A, C, D, E, F, J, K, L, M, N, O, and P housed on the locked unit. The remaining elopement risk, Resident B, was housed on the regular open unit where residents were given codes by staff to use for smoking on the porch. Of the 13 residents identified to have a risk of elopement, Resident A was the only resident pictured or described in the wander book. On 8/19/11 at 10:00 A.M. LPN #1 was interviewed regarding security practices on her open unit. She indicate several alert and oriented residents knew codes and had the capability of letting other residents out or sharing the codes although she did not know if that "happened very much." She indicated Residents G, H and I knew the codes for sure and had free access. On 8/18/11 the porch door of the facility			

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	was observed to be a double wide glass door with a double key pad system of locking and a resonator which was functioning properly when manual numerical code entry was made. Residents were observed to request assistance of staff to enter codes when they were unable to do so, often related to physical inability. Resident G and I were observed to enter the codes and exit the door independently, mid morning several times between 10:00 A.M. and 11:00 A.M. Resident G was asked how to obtain the code and stated "You get it from any of them (referring to staff). There is only one code; it's always the same." An Immediate Jeopardy that began on 6/26/11 was removed on 8/19/11 when the facility reconfigured security codes and implemented a policy prohibiting the codes being given to residents, reassessed and identified all residents at risk of elopement in the facility, revised and updated the Elopement Identification book with resident photographs, and inserviced staff on the changes, but the noncompliance remained at the lower scope and severity level of pattern, no actual harm with potential for more than minimal harm that is not Immediate Jeopardy with the facility continuing to assess implementation and its			

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	effectiveness. This federal tag relates to complaint IN00094056. 3.1-45(a)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to maintain complete clinical records for 1 of 1 resident who had eloped and sustained a fracture, and reviewed for transfer and discharge, in a sample 4. Resident A Findings include: The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included, but were not limited to, schizophrenia, autism, developmental disability and heart disease. The resident had been admitted to Transcendent	F0514	**F514 It is the practice of Transcendent Healthcare of Boonville to assure resident medical records are present, organized, and stored appropriately. *The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #A medical file recording the incident that occurred in June 2011 has not been located. It is the facility's thought that through the process of review, the documentation related to the incident was not replaced in the chart and may have inadvertently been destroyed. The current medical	08/29/2011

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	nursing home on 2/3/11. Business office records indicated the resident had been transferred to a hospital on 6/26/11 following an elopement, and discharged on 7/1/11. Documentation of the event of the 6/26/11 elopement was absent from the medical record as well as all documentation of any staff responses, notifications or communications with either the first hospital ER or the Psychiatric hospital to which the resident was sent. Nursing note narrative documentation was missing from the original 2/3/11 note to the readmission date on 8/8/11. During interview with the current DON on 8/18/11 at 1:00 P.M. and on 8/19/11 at 9:30 A.M., she indicated the documentation was "missing" and she was at a loss to know what happened to it. Following the 7/1/11 discharge, documentation was lacking in the medical record to indicate the required transfer discharge notice, reasons for the discharge and appeal rights information had been provided to either the resident, guardian or the hospital. In interview with the Social Service Designee on 8/19/11 at 1:50 P.M., she stated the appropriate documentation and "all the forms we usually send about that"		file is present and organized. ***Other residents that have the potential to be affected have been identified by:*** All residents' medical records have been reviewed and all others are present and organized. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The nurses and medical records have been in-serviced related to the organization of resident files. The in-service included that if any originals are removed for copying that they be placed directly back into the resident's medical record to prevent loss. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that randomly reviews 5 residents medical records to assure that they are organized and contain all appropriate information. The Director of nursing, or designee, will complete this tool weekly x3, monthly x3, and quarterly x3. Any issues identified will be immediately corrected. The Quality Assurance Committee will review the tools at the scheduled meetings with recommendations as needed ***The date the systemic changes will be completed:*** 8-29-11	

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	were "probably missing" with the rest of the stuff from the chart. This federal tag relates to complaint IN00094056. 3.1-50(a)(1)			
F9999	State finding: 3.1-13 Administration and Management The administrator is responsible for the overall management of the facility but shall not function as a departmental supervisor, for example, director of nursing or food service supervisor, during the same hours. The responsibilities of the administrator shall include, but are not limited to, the following: Immediately informing the division by telephone, followed by written notice within twenty-hour hours, of unusual occurrences that directly threaten the welfare, safety, or health of the resident or residents. This rule was not met as evidenced by:	F9999	**F9999 It is the practice of this facility to assure that Unusual Occurrences are reported to the appropriate agencies as identified per the regulation** ***The correction action taken for those residents found to be affected by the deficient practice include:*** Resident #A resides on the secure unit. There have been no additional attempts to leave the building. ***Other residents that have the potential to be affected have been identified by:*** Potentially all residents could be affected. However, at this time, there have been no attempts of any residents leaving the building. ***The measures or systematic changes that have been put into place to ensure that the deficient practice does not recur include:*** The policy related to reporting of unusual occurrences including elopement has been reiterated to be inclusive of all required elements	08/29/2011

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	Based on record review and interview, the facility failed to report an elopement with resultant fracture and the investigation of same, for 1 of 1 resident who had eloped from the facility in a sample of 4. Resident A Findings include: The clinical record of Resident A was reviewed on 8/18/11 at 9:15 A.M. Diagnoses included, but were not limited to, schizophrenia, autism, developmental disability and heart disease. The resident had been admitted to Transcendent nursing home on 2/3/11. The Minimum Data Set Assessment of 6/26/11 indicated the resident's cognition to be moderately impaired with a score of 12 (8-12 moderate impairment, 13-15 condition intact). It indicated the resident was independent in transfers and ambulation and was always easily distracted or out of touch or had difficulty following what was said. A 7/06/2011 Interdisciplinary Diagnostic and Evaluation Center Significant change analysis provided the only available documentation of the resident's elopement on 6/26/11 in the clinical record that could be located, according to interview with the Director of Nursing on 8/18/11 at 1:30 P.M. Excerpts from that analysis are as		including notification of appropriate agency notification. All staff has been in-serviced related to the policy. ***The corrective action taken to monitor performance to assure compliance through quality assurance is:*** A Performance Improvement Tool has been initiated that will be utilized to review the proper following of the Reportable Occurrences Policy including notification of the appropriate state agencies. It is the Administrator's responsibility to assure that the appropriate agencies are notified of any reportable event. The Administrator, or designee, will complete this audit monthly x3, then quarterly x3. The Quality Assurance Committee will review the tool at the scheduled meeting following the completion of the tool with recommendations as needed. ***The date the systemic changes will be completed:*** August 29, 2011	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	follows: "...admitted to Transcendent 2/3/11...admitted to (Name) Psychiatric Hospital in March 2011 where she was held for 72 hours due to threats to leave the nursing facility...most recent admission to [Psychiatric hospital] was on 6/27/2011 after she snuck out of the nursing facility after 11:00 P.M. on 6/26/11... She related afterwards, she was going to purchase cigarettes. However her roommate at the nursing facility told staff that (Resident name) was going to meet a man the roommate knew and had arranged to meet (Resident name). The man's name was learned but it is not known if (Resident name) actually met up with him. When the nursing facility did their resident census at midnight they found she was missing from her bed. After a search of the facility with administrative personnel called in to help search and family notified, the facility received a call from (Name) Hospital Emergency Room to inform them the resident had been brought there for treatment." Documentation was lacking to indicate the facility had reported the incident with injury or its investigation results to the appropriate State Agencies.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155508	A. BUILDING 00 B. WING	08/19/2011

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	On 8/18/11 in separate interviews with the Administrator at 1:20 P.M. and the Director of Nursing at 12:50 P.M., they each indicated their knowledge of the incident having occurred but indicated they had been in orientation to assume their duties in their positions during the time frame of the incident and subsequent investigation. They were not the Administrator and Director of Nursing of the facility at the time, and could not address the failed reporting, not having been responsible on the date of the incident. They verified all documentation from the medical record regarding the specific incident was missing for unknown reasons. This state finding relates to complaint IN00094056. 3.1-13(g)			